Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS664HOS	A. BUILDING _____ B. WING _____	04/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL LAS VEGAS	5110 W SAHARA AVE LAS VEGAS, NV 89146

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S 000	Initial Comments This Statement of Deficiencies was generated as the result of a state licensure complaint investigation survey conducted at your facility on 04/10/09. The survey was conducted using the authority of NAC 449, Hospitals, last adopted by the State Board of Health on August 04, 2004. The following complaints were investigated. Complaint #NV00020418 - Unsubstantiated Complaint #NV00020549 - Unsubstantiated Complaint #NV00019107 - Unsubstantiated Complaint #NV00019395 - Substantiated (Tag S310) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified.	S 000		
S 310 SS=D	NAC 449.3624 Assessment of Patient 1. To provide a patient with the appropriate care at the time that the care is needed, the needs of the patient must be assessed continually by qualified hospital personnel throughout the patient's contact with the hospital. The assessment must be comprehensive and accurate as related to the condition of the patient. This Regulation is not met as evidenced by: Based on interview, record review and document	S 310		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 310	Continued From page 1 review the facility failed to conduct a comprehensive and accurate assessment of the care and needs of a patient when there was a significant change in the patients condition. (Patient #1) Findings include: Patient #1 was admitted to the facility on 04/27/08 with diagnoses including anoxic encephalopathy, ventilator dependent respiratory failure, traumatic brain injury and multiple complications of chronic persistent vegetative state. The Physician Transfer Summary dated 09/12/08, indicated the patient had been transferred to another hospital for central line placement and they noticed the patients right arm was swollen and had bullae on it. The physician spoke with the charge nurse, RN #1 who thought the swelling was due to an intravenous infiltration, although there was no documentation the physician was aware of. "The patient had bullae on the palm of his hand and the right forearm. There was some loss of the epidermis where one of the bullae had ruptured. The patient's right arm was tense and mildly swollen. It was difficult to feel palpable pulses. He seems to have capillary refill in the extremities at this time. There is no obvious redness or warmth. We are going to send the patient to another hospital for admission for possible early compartment syndrome and rule out any type of soft tissue infection and monitor his arm as it is very nasty looking at this time. It is really unclear etiology in my mind." A Surgery Progress Note by Physician Assistant (PA) #1 dated 09/12/08, included, "I have been asked by the charge nurse, RN #1 to evaluate possible IV (intravenous) extravasation wound on	S 310		

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S 310	Continued From page 2 right hand. Exam reveals the entire right forearm is tense and severely edematous with multiple bullae and possible fluid and gas filled blisters over much of the posterior forearm, dorsal hand and dorsal digits. The patient's radial pulse was non palpable due to severe edema. There was no specific site of trauma, inoculation or eschar noted. The assessment/plan indicated possible gas gangrene or compartment syndrome." A Physicians Transfer order dated 09/12/08, indicated the patient was to be transferred to another hospital for evaluation for possible infection/compartment syndrome of the right forearm. On 04/10/09 at 10:30 AM, RN #1 indicated the swelling on Patient #1's right forearm was brought to her attention by personnel who had responded to transport the patient to another hospital. RN #1 indicated the patient had an order to be transferred to another hospital for a Porta Cath placement. When transporters were at the facility to pick the patient up they noticed swelling and blisters to the patient's right arm and reported it to staff nurses at the facility. RN #1 thought the swelling could have been caused by an IV infiltration but had no knowledge that occurred. RN #1 indicated she mentioned a possible IV infiltration to PA #1 prior to his exam and asked PA#1 to examine the patient. RN #1 indicated nursing staff had difficulty starting a peripheral IV in the patient. RN #1 acknowledged there was no documentation in the nursing notes that described the blisters on the patients right arm or a change in the patients condition. On 04/10/09 at 12:00 PM, RN #2 reviewed the nursing notes for Patient #1 and acknowledged the nursing staff failed to document a change in	S 310		

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S 310	Continued From page 3 Patient #1's condition in regards to the patients Heparin Lock in his right arm that was discontinued sometime after 09/10/08 and the swelling and blistering to the patient's right arm discovered by personnel transporting the patient to another hospital for central line placement. RN #2 acknowledged the nurses were required to document a change in the patient's condition in the nursing notes and report a significant change in the patients condition to a physician. Nursing Notes dated 09/10/08 at 8:05 AM, indicated the patient had a Heparin Lock #22 gauge angiocath in the dorsum of the right hand. The site was clear and the dressing was dry and intact. Nursing Note dated 09/11/08 at 5:37 AM, indicated: "Heparin Lock #22 gauge angiocath left forearm infusing." Nursing Note dated 09/11/08 at 12:01 PM, indicated: "Phenytoin IVPB (intravenous piggy back) 200 mg (milligrams) at 9:00 AM not done, no IV access at this time, pharmacy and charge nurse aware." Nursing Note dated 09/11/08 at 11:03 PM, indicated: "bilateral arms + 2 edema." Nursing Note dated 09/11/08 at 11:07 PM, indicated: "site no IV access." Nursing Note dated 09/12/08 at 10:50 AM, indicated: "swelling right arm." Nursing Note dated 09/12/08 at 10:44 AM, indicated: "No IV access at this time, off unit for central line to another hospital."	S 310		

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S 310	Continued From page 4 A review of the patients Medication Administration Record for 09/11/08, indicated the patient was receiving Phenytoin 200 mg IVPB. A Hospital History and Physical dated 09/13/08, indicated the patient was transferred from the facility to a hospital, then to another hospital for sores on his right arm. The patient was seen and treated for partial thickness burns, (4%) to his right arm. The patient had no recent trauma. It was unclear what exposures the patient had at the facility. The patient had recently been on Rifampin as well as Zyvox antibiotics. A Hospital Consult dated 09/13/08, indicated the patient was in a nursing home where he apparently had a skin burn which was suspected secondary to antibiotic rather than thermal injury and subsequently was transferred to this hospital for wound evaluation by the burn care team. Impression: "The patient was admitted with right upper extremity burn appearance secondary to suspected antibiotic related. It appears as a burn but not a thermal burn. Further management per wound care and burn care." A Hospital Trauma Consultation dated 09/13/08, indicated the patient had a right upper extremity burn. "There was a large tense blister on the palm of the right hand measuring approximately 6x4 cm (centimeters). There was a circumferential burn covering the forearm halfway to the elbow. There were several blisters of various sizes and an ulceration measuring 9x6 cm on the distal forearm on the ventral surface. This was a partial thickness deep centigrade burn that blanched with pressure. Impression: Circumferential deep second degree burn covering approximately 4% total body surface	S 310		

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S 310	Continued From page 5 area on the right upper extremity." The facility Documentation Guidelines Policy last revised 12/18/07, indicated under Policy: "The hospital initiates and maintains a medical record for every admitted individual assessed or treated. Documentation in the medical record is detailed, organized, and contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document course and results, and promote continuity of care among health care providers." Procedure: "To facilitate consistency and continuity in patient care, the medical record contains specific data and information including: 1. The record and findings of the patient's assessment. 2. Progress notes made by the medical staff and other authorized individuals, all reassessments and any revisions in the treatment plan. 3. Clinical observations, including change in condition. 4. Every dose of medication administered and any adverse drug reaction; all relevant diagnoses established during the course of care." The facility IV Sites/Systems Assessment/Care/Maintenance Policy last revised 12/01/06, included under Procedure; "Patients receiving IV therapy will have the IV system and the IV site assessed at least every shift. Assessments will be documented in the patient's medical record. Assessments will include devices being utilized, solution, and flow rate, condition of the site including dressing patency."	S 310		

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S 310	Continued From page 6 Prentice Hall Nurses Drug Guide 2007, included under adverse effects of intravenous Phenytoin documented under Skin: morbilliform bullous, exfoliative, or purpuric dermatitis, Stevens-Johnson syndrome, toxic epidural necrolysis." Monitor site for extravasation because medication can cause severe tissue damage." Severity: 2 Scope: 1 Complaint #NV00019395	S 310		